



A Study of the Primary Health Care Facilities in the Rural West Bengal

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KEYWORDS

Primary Health Centre (PHC), Sub-Centre (SC), Primary health care, Public health, National Rural Health Mission (NRHM)

ABSTRACT

The present article seeks to understand the recent scenario of primary health care facilities, personnel and delivery of related services in the context of primary health care in rural West Bengal. A qualitative research design has been chosen and one Primary Health Centre and four Sub-Centres of the Paschim Medinipur district have been purposively selected for this study. Data have been collected through 1) participant observation on the processes of service delivery and 2) unstructured interviews with both medical and non-medical staffs. Data analysis and interpretation were based on the thematic content analysis method. In rural areas, the Sub-Centre is the first contact point between the primary health care system and the community whereas the Primary Health Centre is the first contact point between the community and the medical officer. According to the doctors and health workers, shortcomings in manpower, supplies and infrastructure are crucial determinants for the quality of care and also influence utilization of these facilities.

Introduction

A majority of the Indian population, almost 70 percent (Census 2011), lives in rural areas where the public provision of health care is of great importance. The private health sector has grown considerably over the last few decades. However, in rural India where the private sector is virtually non-existent, except for a few quacks, the services provided by the public sector health care system are most important as they are available, accessible and affordable to people. Primary Health Centres (PHCs) and their Sub-Centres (SCs) are central to the rural health care system, established and managed by the public sector (Sankar and Kathuria 2004).

From its earliest days, anthropology has included research regarding health (Sobo 2004). Anthropological research can provide deeper understandings of social processes underpinning health issues (Chapman and Berggren 2005). It is contextual to quote Campbell (2011: 76), 'many people in the fields of medicine and public health do not understand the potential role that anthropology could play in the development of public health policy.' Public health is the organized efforts to improve the health of communities (Novick and Morrow 2007). Hahn and Inhorn (2009) argue that the lack of routine and systematic use of anthropological theory and method has been detrimental to the field of public health. Public health needs anthropology to be maximally effective. Presently, the principal contributions of anthropology in four crucial public health domains are said to be: a) anthropological

understandings of public health problems; b) anthropological design of public health interventions; c) anthropological evaluations of public health initiatives; and d) anthropological critiques of public health policies (Hahn and Inhorn 2009).

The present study tries to reach a deeper understanding of the primary health care system of West Bengal, especially public health care facilities at grass and root level in terms of infrastructure, human resources and service delivery. It also tries to identify the problems these facilities are currently facing from the insiders' perspectives of various personnel using an ethnographic lens.¹

Backdrop

In India, the public sector health care system has a three-tier structure comprising primary, secondary and tertiary health care institutions to deliver necessary services. The primary tier has been developed to deliver primary health care (includes basically preventive, promotive and some basic curative care) to the vast majority of rural people. Based on predetermined population norms, this tier consists of three types of health care institutions, viz., a Sub-Centre for 3,000 to 5,000 people, a Primary Health Centre for a population of 20,000–30,000 and a Community Health Centre (CHC) as the referral unit every four PHCs covering a population of 80,000 to 120,000 (Planning Commission 2001). SCs and PHCs are two most important facilities of primary health care services to rural people. They constitute the lower rung of the hierarchical health care system. The secondary tier includes the district hospitals whereas the tertiary tier is composed of urban health care institutions well equipped with sophisticated diagnostic and investigative facilities.

The Sub-Centre is the most important health institution, being the closest to the community, for the surveillance and prevention of diseases as well as promotion of good health. It also acts as the lowest forum for convergence of functioning of the public health workers, Panchayati Raj functionaries, Integrated Child Development Services (ICDS) workers and other civil society members. According to Rural Health Statistics (2014), the number of the Sub Centres in India is 152,326. However, there is a shortfall of 36,346 SCs (20 per cent) across the country as per the RHS data. The state of West Bengal has 10,356 SCs catering to around 622,000 rural people (Census 2011). Thus, the average population covered by one SC comes to around 6,000 against the norms of 5,000 (3,000 in tribal, hilly and backward areas). Thus, on a normative basis there is a shortage of more than 2,000 SCs but in practice, the shortage of SCs is around 3,000 or even more (Government of West Bengal 2013).

The PHC is the first contact point between the community and the medical officer. A CHC is a referral centre for four PHCs within its jurisdiction, providing facilities for obstetric care and specialist expertise. There are 25,020 PHCs and 5,363 CHCs functioning in the country as on 31st March 2014 (RHS 2014). Data also reveals 23 per cent and 32 per cent shortfall in the former and latter facilities. In West Bengal, the numbers of total functioning PHCs and CHCs are 909 and 147 respectively (Census 2011). The shortfall of a PHC is far greater in West Bengal (58 per cent) than that of the entire country. SCs and PHCs are the two most important facilities of primary health care services to rural people. Many actions have been taken after the introduction of the National Rural Health Mission since 2005. However, a large number of lacunae still remain.

The concept of Primary Health Centre (PHC) is not new to India. The Report of the Health

1 Ethnography is particularly useful in understanding the organization of health care (Morse and Field 1996)

Survey and Development Committee (1946) was the first policy statement on health in India, also known as the Bhore Committee Report, which stressed the availability of health care to rural people regardless of ability to pay and recommended a three-tier health care system (Bhore 1946). Consequently, health planners accepted the PHCs and the SCs as the proper infrastructures to provide health services to the rural population. In 1951, the Central Council of Health advised the establishment of PHCs at community development block level. After that many committees were formulated to look into the country's health situation (e.g. Mudaliar Committee of 1962, Shrivastav Committee of 1975). Most of them mentioned and recommended the development of effective rural health services. A paradigm shift occurred in the health services globally as well as nationally after the Alma Ata Convention on Primary Health in 1978. According to the declaration:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (WHO 1978: 2)

Following the Alma Ata declaration, in 1982, the Government of India formulated its first National Health Policy committed to achieve 'Health for All by 2000' through the comprehensive primary health care approach (MoHFW 1982). It gave importance to the overall health care delivery system especially the preventive, promotive and rehabilitative aspects of health care for the population in the remotest corners of India and had an immense focus on the community involvement to health services. The results were mixed and it was revised with an updated health policy in 2002 (MoHFW 2002). On 01 April 2005, the Government of India introduced the National Rural Health Mission (NRHM) (MoHFW 2005). Later the Union Government launched the National Urban Health Mission (NUHM) on 01 May 2013 (MoHFW 2013). Now these two missions were brought together under the National Health Mission (NHM).

Objectives

Anthropology has been interested in public health for many years and its more specialized sub-discipline, i.e. medical anthropology as a relative newcomer in academia is also not very new to that arena (Campbell 2011).² The present study aims to trace the Primary Health Care network consisting of both Primary Health Centres and Sub-Centres in relation with the service delivery to rural communities. There is a limited number of such studies, especially from the perspective of anthropology (or medical anthropology), in the Indian context, that have made an effort to understand public health issues by using an ethnographic approach.³

² Medical anthropology 'is about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in, and to whom they turn if they do get ill' (Helman 1994:1).

³ The ethnographic approach has become a popular method in health related research (Hammersley and Atkinson 1995).

The objectives of this study are mainly twofold:

- the present scenario of public health infrastructure for the primary health care in rural West Bengal, including infrastructure, personnel and delivery of related services; and
- health care providers' view on problems at the level of SCs and PHCs.

Methodology

A qualitative research design has been chosen as it can play an important role in public health care design because they can provide contextual data about health care settings, especially the people, processes and patterns that constitute the daily work of providing health care (Johnson and Barach 2008). One Primary Health Centre and four of eight Sub-Centres under its jurisdiction have been purposively selected for this study. The PHC is situated in the Paschim Medinipur district at a distance of 10–12 kilometres away from the district headquarters. The study was carried out during the calendar year 2013 (February–April). Considering ethical issues the names and addresses of the selected Primary Health Centre and Sub-Centres are withheld.

Both primary and secondary data were collected to meet the research objectives. Primary data were collected from the study participants. Secondary data were collected from published articles available on the internet as well as from printed reports and books. Mainly two sets of primary data have been collected at the study settings through: 1) participant observation on the processes of clinical interaction and service delivery and 2) thematic and semi-structured interviews with both medical and non-medical staffs. Most of the participants were interviewed once or twice with cautious ethical measures. Interviews with all of them were made in Bengali. All interviews were recorded, transcribed and reviewed by researchers with the help of field notes.

Thematic content analysis was selected as the qualitative data analysis method. It is very useful for the categorization of verbal and behavioural data for the purpose of classification, summarization and tabulation. After carefully reviewing the data and transcriptions, it involved the identification of a) different but frequent themes, b) possible relationships between themes and c) insightful responses for further descriptive and interpretative analysis. Analysis, interpretation and conclusions were carefully made using the proper theoretical guidelines without distorting the present research context.

Findings

The Sub-Centre (SC)

The purpose of the Sub-Centre is largely preventive and promotive, but it also provides a basic level of curative care. As per population norms, there shall be one Sub-Centre established every 5,000 people in plain areas and every 3,000 people in hilly and tribal areas (MoHFW 2012a). Sub-Centres are expected to provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases. There should be two auxiliary nurse-cum-midwives (ANMs), one health worker male and one voluntary worker

in each SC. Two SCs had two ANMs and the rest had only one ANM. None of the SCs had any other required staff. So shortfalls of manpower were noticed in all the SCs with varied severity. All the studied SCs had health assistant females (or first ANMs) as the main responsible persons for serving local rural residents and locally known as *swasther didimoni*. All of them had spent at least ten to fifteen years of their service life in their respective SCs and sometimes operated single-handedly. Recently the engagement of a second ANM came into existence to assist in outreach and clinical work and to facilitate possible normal delivery at SC level. Only two SCs were fortunate to get the service from them. The NRHM introduced the Accredited Social Health Activists (ASHAs) on an incentive basis for working at the community level and maintaining close contacts with mothers and the children. ASHA workers were selected from the community level and oriented on different public health related issues through training. At the time of the study, many of them started working in the allotted areas but still many positions lied vacant.

Previously all the SCs were in rented buildings with scanty (sometimes minimal) infrastructure. Now all of them were shifted to newly constructed government establishments, although at the time of the study, three out of four new buildings were not fully operational and devoid of infrastructural facilities like labour room, electricity, running water supply, toilet and wastage disposal. The only fully complete SC was adjacent to its respective Gram Panchayat (GP) office.

The SCs mainly deal with maternal and child health (up to five years old) and offer services related to 1) both ante natal and post natal care; 2) immunization; 3) family planning and 4) referral services. They also provide first aid in accidents and basic drugs for minor ailments like fever, cold and cough, diarrhoea, etc. SCs also acted as the DOT and MDT centre for controlling Tuberculosis (TB) and Leprosy.^{4, 5} All the SCs attempted to provide the above mentioned consulting services, field services, family planning and sterilization facilities as well as free medicines including oral items, injections etc. to rural communities of the adjacent area. Routine check-up and immunization were done in both clinic and outreach mode. Institutional delivery was not possible in any of these facilities and was a matter of referral to the PHC. Recent activities like organizing village health and sanitation day, mothers meeting, the 3rd and 4th Saturday's meetings helped health workers to increase awareness generation. To them, convincing women to take the semi-permanent method of contraception (e.g. copper IUD) and controlling tuberculosis, leprosy were a little bit more difficult than other regular tasks.⁶

Most Sub-Centres have various technical problems in providing top quality service. They have to serve large populations with inadequate infrastructures, limited manpower and insufficient resources. Previously the aforesaid problems were acuter in nature. More or less all health workers faced similar obstacles. The situation has changed over time and especially after the introduction of the NRHM. The infrastructural growth and engagement of new personnel have resulted in a better service delivery but still there are lacunae. Physical inaccessibility is a great problem as transportation facilities are not well equipped here. For instance, one of the studied SCs is situated near the jungle where catchment villages are situated at a distance and dispersed in nature. In her own words:

...I am the only staff in this Sub-Centre. Neither the second ANM nor the health workers

4 Directly observed treatment.

5 Multi-drug therapy.

6 Intrauterine device.

are available. I have to serve alone all the villages situated at the jungle area. One of the villages is as far as 18 kilometres away from the Sub-Centre. The communication problem is so acute that sometimes patients are not very willing to come to the SC. Organizing outreach camps at regular intervals is the only effective way. Recently the facility has shifted to another place but is still not fully operational due to the non-availability of electric and water connections. It is a tribal area and occurrences of TB are pretty high among the inhabitants. So, the numbers of DOT defaulters are also high and alcoholism is the main barrier to their cure...

Irregular supply of medicine and drug kits often leads to delay of service, referral to higher units and seeking treatment from quacks. For example, the limited availability of oral rehydration solutions (ORS) was reported during the fieldwork. To them, underage marriage and early pregnancy are two important public health problems in this area. In the case of family planning, the participation from both sexes is not equal and females are keener to take temporary as well as permanent methods than their male partners. One important finding has emerged i.e. the occupational tension between health workers and ASHA workers.

...ASHA workers are not getting their incentives regularly. As a result, they are not very willing to do their duties. All of them are not educated enough for their job. Sometimes they do not complete their assigned tasks because they are unsure about what to do or how to do it...

The Primary Health Centre (PHC)

Primary Health Centres (PHCs) comprise the second tier in the rural healthcare structure expected to provide integrated curative and preventive healthcare to the rural population with an emphasis on the preventive and promotive aspects. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). A PHC is established with a population norm of 20,000 people for hilly and tribal areas and 30,000 people for plain areas (MoHFW 2012b). It is also required to serve six Sub-Centres within its jurisdiction. One medical officer is in charge of the PHC supported by fourteen paramedical and other staffs. Theoretically, the PHC having the necessary facilities and skilled manpower does not face serious issues in dealing with any type of disease or public health problem. But in reality, the picture is gloomy rather than shiny with struggling performances and many hiccups in service delivery. Many PHCs have to refer serious and complicated cases to the CHCs or other hospitals due to various technical and operational constraints such as the absence of specialist doctors, poor availability of beds, staff inadequacy and poor or no infrastructure services such as power, running water, ambulance, etc.

The studied PHC was suffering from an acute case of shortcomings in manpower. The data revealed that except in the case of two medical officers (MO), one pharmacist and four staff nurses all the other posts were not filled in compliance with the guidelines. As for the two medical officers, the senior one had been working since 1986, and the other since 1998. The post of medical officer in charge was residential so that the doctor was full time available at the PHC facility. Due to staff shortage, the other MO had to serve both the PHC and the nearby rural hospital simultaneously. At the time of this study, this facility had only three sub-staffs and one sweeper. Still there were many posts like health educator, health assistant, laboratory technician and clerk that remained vacant.

The PHC had ten beds for in-patients and functioned round the clock. It had its own government-

run buildings and demarcated compound. The boundary walls were painted in the Bengali language depicting the services offered. The main buildings were not well maintained and there was a general lack of hygiene and cleanliness. Water and electricity were available regularly at this facility. It had a functional labour room and a 'make shift' operation theatre. Separate check-up rooms for women, office rooms and a drug store were also present. Modern facilities like a clinical test unit, x-ray unit and blood bank were absent in case of this PHC. The conditions of the staff quarters were simply uninhabitable, therefore the staff nurses could not live in this facility.

A typical PHC provides outpatient department (OPD) services like consultation, few routine clinical tests, immunization, mother and child health care activities, outreach sessions, as well as family planning and sterilization in addition to dispensing drugs including pills, injections, vaccines, drips, etc. The PHCs also have round the clock inpatient department (IPD) services, viz., bed facilities for admitting patients who require the continuous care of medical staff. An equally important role of the PHCs is to educate the public falling under the purview of the PHCs on the virtues of family planning, hygiene, sanitation and good health. The MOs reported that they were trying to provide all possible services according to the guidelines. The PHC provided OPD and round the clock IPD services with limited facilities for normal delivery and very few routine laboratory tests. One SC was attached with this PHC and jointly these two facilities catered the need for maternal and child health care, family planning and immunization. It had few advanced facilities like baby warmers for neonates, provision of anti-venoms, etc. It also rendered the other primary health care service like the treatment of common diseases and injuries, provision of essential drugs and prevention and control of locally endemic diseases. Apart from common ailments, many injuries in the workplace were treated by this facility. It also conducted national health programmes as relevant such as the filaria elimination programme (once a year), non scalpel vasectomy (NSV) camp, etc. It acted as a referral unit for eight Sub-Centres.

The studied PHC covered a population higher than the prescribed norm. MOs have been reported providing services according to the Indian Public Health Standards (IPHS) guidelines. It is one of the better performing PHCs having a fully functional in-patient ward. The quality of the health care and medical services and their utilization depends on the availability of doctors, para-medical staff and requisite essential complementary facilities. There are genuine problems of effective staff strength which hinder the quality of the services and their utilization. The work burden is increasing day by day with the depleting number of personnel. Availability of physical infrastructure is crucial for the staff to perform better. This PHC lacks infrastructural components like a well-equipped operation theatre, an ambulance, livable staff quarters, etc. It is also devoid of modern diagnostic facilities and pathology laboratory. Oftentimes, the unavailability of medicines due to lack of supply may lead to patient dissatisfaction. The medical officer in charge expressed his concerns:

... The posts of the pathologist, health educator, health assistant, office clerk and other support staff have been vacant for a long times. To improve the quality of the service, this facility should be made equipped with the necessary infrastructure and diagnostic facilities. Moreover, medicines should be made available in the PHCs all the time round the year. We are aware of the problems of the villagers, but sometimes, we fail to deliver appropriate service because of our limitations. There is a need for systematic monitoring and reviewing of the PHCs on a regular basis to overcome the service constraints...

Conclusion

Primary health care is a very important feature of our country's health system. PHCs and SCs constitute the lowest and second lowest rungs of a referral pyramid of primary health care facilities in rural areas. The PHC is the cornerstone of rural health services – the first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or refer from SCs for curative, preventive and promotive health care (MoHFW 2012b). On the other hand, the SC is the most peripheral and first point of contact between the primary health care system and the community. It provides an interface with the community at the grass and root level, providing all the primary health care services (MoHFW 2012a).

Anthropology has long been associated with public health and has a special relevance to public health issues. Public health care provisions in India, especially in the rural areas, should be thoroughly studied through the ethnographic lens. Moreover, scanty numbers of such studies make them much needed in the world of academia. In this situation, the present study attempts to understand the primary health care institutions, including both PHCs and SCs, in terms of service delivery to the rural communities from an anthropological perspective. It also tries to identify the health care providers' view on problems at the grass and root level of operation.

The findings are categorized in line with the three broad headings: human resource, physical infrastructure and services. The services rendered by the PHC network are deficient in some areas but still there are scopes for betterment by making all the facilities fully functional for related services. Most facilities serve huge populations with insufficient physical infrastructure, limited personnel and scanty resources. The condition has somewhat improved after the advent of the NRHM with the engagement of extra personnel, better fund flow and enhanced supplies. There are still needs to be met such as regular supplies of drug kits, substantial fund allocation, systematic monitoring, better training, incentives for the staff, etc. Furthermore, ample community support and participation are necessary for making primary health care services successful and people-oriented.

References:

- Administrative Training Institute. (2013). *Public Health in West Bengal – Current Status and Ongoing Interventions*. Kolkata: Government of West Bengal.
- Bhore, J. (1946). *Report of the Health Survey and Development Committee*. Volume I to IV. Delhi: Government of India.
- Campbell, D. (2011). "Anthropology's Contribution to Public Health Policy Development". *McGill Journal of Medicine*, 13(1):76–81.
- Chapman, R. R., and Berggren, J. R. (2005). "Radical Contextualization: Contributions to an Anthropology of Racial/Ethnic Health Disparities". *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 9(2):145–67.
- Hahn, R. A., and Inhorn, M. (2009). *Anthropology in Public Health: Bridging Differences in Culture and Society* (2nd ed.). New York: Oxford University Press.
- Hammersley, M., and Atkinson, P. (1995). *Ethnography: Principles in Practice* (2nd ed.). London: Routledge.
- Helman, C. G. (1994). *Culture, Health and Illness: An Introduction for Health Professionals* (3rd ed.). Oxford: Butterworth-Heinemann.
- Johnson, J. K., and Barach, P. (2008). "The Role of Qualitative Methods in Designing Health Care Organizations". *Environment and Behavior*, 40(2):191–204.
- Ministry of Health and Family Welfare. (1982). *National Health Policy*. Delhi: Government of India.
- Ministry of Health and Family Welfare. (2002). *National Health Policy*. New Delhi: Government of India.

- Ministry of Health and Family Welfare. (2005). *National Rural Health Mission – Mission Document*. New Delhi: Government of India.
- Ministry of Health and Family Welfare. (2012a). *Indian Public Health Standards (IPHS) Guidelines for Sub-Centres: Revised 2012*. New Delhi: Government of India.
- Ministry of Health and Family Welfare. (2012b). *Indian Public Health Standards (IPHS) Guidelines for Primary Health Centres: Revised 2012*. New Delhi: Government of India.
- Ministry of Health and Family Welfare. (2013). *National Urban Health Mission: Framework for Implementation*. New Delhi: Government of India.
- Ministry of Health and Family Welfare. (2014). *Rural Health Statistics 2013–14*. New Delhi: Government of India.
- Morse, J., and Field, P. (1996). *Nursing Research: The Application of Qualitative Approaches* (2nd ed.). London: Chapman and Hall.
- Novick, L. F., and Morrow, C. B. (2007). “Defining Public Health: Historical and Contemporary Developments”. In L. F. Novick, C. B. Morrow, and G. P. Mays (eds.), *Public Health Administration: Principles for Population-Based Management* (2nd ed.), pp. 1–34. Sudbury, MA: Jones and Bartlett Publishers.
- Planning Commission. (2001). *Evaluation Study on Functioning of Primary Health Centres (PHCs) Assisted under Social Safety Net Programme (SSNP)*. New Delhi: Government of India.
- Registrar General. (2011). *Census and Vital Statistics*. New Delhi: Government of India.
- Sankar, D., and Kathuria, V. (2004). “Health System Performance in Rural India: Efficiency Estimates across States”. *Economic and Political Weekly*, 39(13):1427–33.
- Sobo, E. J. (2004). “Theoretical and Applied Issues in Cross-Cultural Health Research”. In C. Ember, and M. Ember (eds.), *Encyclopedia of Medical Anthropology: Health and Illness in the World's Cultures* (Vol. 1), pp. 3–12. New York: Kluwer Academic Publishers.
- World Health Organization. (1978). *Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR*. Geneva: WHO.